

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16928

20210

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) J. Louis Anderson		4. DATE OF DEATH Month Dec. Day 8 Year 1965			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7-1891		
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HRS. Hours 15 Min. 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Grumpton, Maryland	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME James Anderson		
14. MOTHER'S MAIDEN NAME Ella Leager			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		
16. SOCIAL SECURITY NO. 220-26-8207A			17. INFORMANT Address Md. Mrs. J. Louis Anderson-Sudlersville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic Hypertension DUE TO General Arteriosclerosis (c) 0 Bury - In hospital - Virus					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 Bury - In hospital - Virus					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. N/A p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1965 to Dec 5, 1965 that (I) (we) last saw the deceased alive on Dec 6, 1965, and that death occurred at 8 A.M. from the causes and on the date stated above.					
22a. SIGNATURE C.H. Metcalfe		22b. DATE SIGNED 12/10/65			
22c. PHYSICIAN'S NAME (Type) C.H. Metcalfe		22d. ADDRESS Sudlersville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 11		23c. NAME OF CEMETERY OR CREMATORY Sudlersville,	
23d. LOCATION (City, town or county) (State) Sudlersville, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane			
25a. REC'D BY REGISTRAR DEC 15 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Q. A.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE md. b. COUNTY Q. A.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chester				c. LENGTH OF STAY in 1b Lifetime							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chester				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First Birdie Middle Bertha Last Brown				4. DATE OF DEATH Month 12 Day 21 Year 1965				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/03		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months — Days —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Jones				14. MOTHER'S MAIDEN NAME Sarah Jane White							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —		17. INFORMANT Lloyd Holden		Address Chester, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive C-V Disease (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —										INTERVAL BETWEEN ONSET AND DEATH Immediate ? yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —		(State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Irvin G. Hoyt				M.D. —				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Irvin G. Hoyt MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/22/65			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-25-65		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or country) Green Anne MD			
23. FUNERAL DIRECTOR ADDRESS James B. Marshall Easton Md						24a. REC'D BY REGISTRAR DATE DEC 28 1965		24b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16930

20312

1. PLACE OF DEATH a. COUNTY <u>Queen Ann's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Ann's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Ann</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Ann's Md</u>	
c. LENGTH OF STAY IN 1b <u>4 years</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Broad Street</u>	
3. NAME OF DECEASED (Type or print) <u>James Walter Calloway</u>		4. DATE OF DEATH <u>Dec 11</u> 19 <u>65</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1880</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H Calloway</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HARRINGTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Dorothy Towers</u>		Address <u>Queen Ann's Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper Resp. Infection</u> 4221 DUE TO (b) <u>Arteriosclerotic Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Twelve</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec 14 1965</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		23d. LOCATION (City, town or county) (State) <u>HOLLSBORO, MD.</u>	
24. FUNERAL DIRECTOR <u>J. VIRGIL MOORE DENTON MD.</u>		25. REG'D BY REGISTRAR <u>DEC 16 1965</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. REGISTRAR'S NAME (Type) <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16931

20313

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> c. LENGTH OF STAY IN ID <u>all his life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Centreville</u> d. STREET ADDRESS <u>Route # 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert David Dill</u> First Middle Last		4. DATE OF DEATH <u>Dec 3 1965</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12 1898</u> 9. AGE (in years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>QUEEN ANNE'S Co, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William C. Dill</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Clara Shaban</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-32-2456</u>		17. INFORMANT <u>JAMES A. Dill, Route # 3, Centreville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cotornary Occulion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arthro selexosis Cardio Vascular years</u> (c) <u>Discae</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Potory Myocardial infarct</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u> EXAMINER'S NAME (Type) <u>C. R. Layton</u>		22. DATE SIGNED <u>12-5-65</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Centreville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>DEC 6, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park Inc</u>	23d. LOCATION (City, town or county) (State) <u>Talbot County Maryland</u>
24. FUNERAL DIRECTOR <u>James H. Butts - Butts Bros, Centreville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1965</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY QUEEN ANNE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 102 S. Liberty Street	
3. NAME OF DECEASED (Type or print) First Abraham Middle Jacob Last Epstein		4. DATE OF DEATH Month DEC. Day 26 Year 1965	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 22, 1904
9. AGE (in years last birthday) 61 yrs.		10. IF UNDER 1 YEAR (If under 24 HRS. Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Dry Goods	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL EPSTEIN		14. MOTHER'S MAIDEN NAME LIZZIE SYMNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) NW II		16. SOCIAL SECURITY NO. 218-20-8168	
17. INFORMANT Miss Sarah Epstein		Address CENTREVILLE, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H2patic Failure with 5810 DUE TO (b) Hepatic Coma DUE TO (c) Cirrosis of Liver Nodular PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 mo 15 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUG 30, 1965 to DEC 26, 1965 , that (I) (we) last saw the deceased alive on DEC 26, 1965 , and that death occurred at 10:29 AM , from the causes and on the date stated above.			
22a. SIGNATURE C. R. Boyton		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. R. Boyton		22d. ADDRESS Centreville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 29, 1965	
23c. NAME OF CEMETERY OR CREMATORY Roosevelt Memorial Park		23d. LOCATION (City, town or county) (State) Bucks County, PA.	
24. FUNERAL DIRECTOR James H. Babin, Baltimore, Centreville, Md.		25a. REC'D BY REGISTRAR DEC 29 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

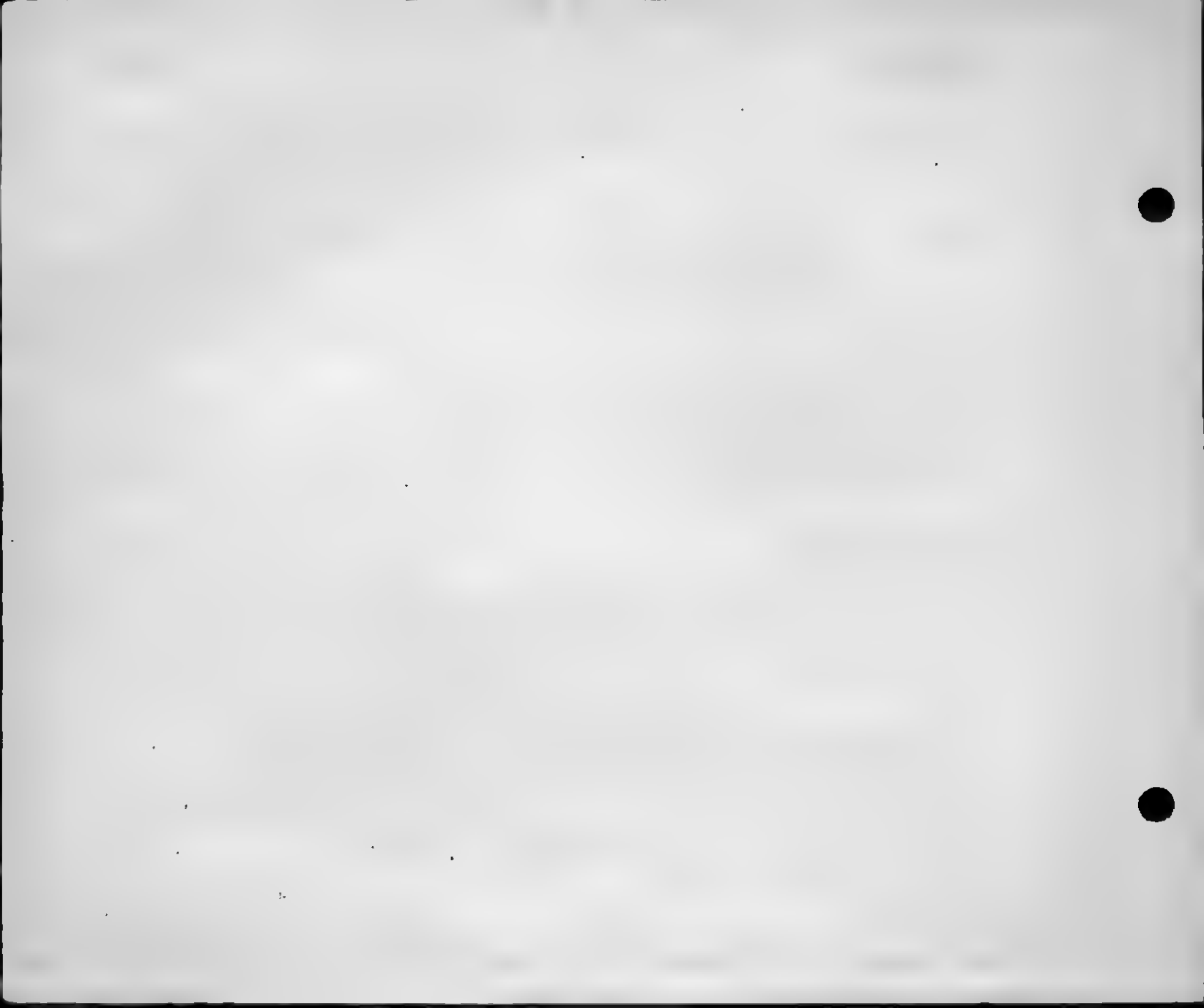
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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grasonville Rural</u> c. LENGTH OF STAY IN b. <u>18 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grasonville Md.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julia</u> First <u>Lewis</u> Middle Last 4. DATE OF DEATH <u>Dec. 21</u> Month Day Year <u>1965</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 16</u> 19 <u>41</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>strucking marmite</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Augustus Crawford</u> 14. MOTHER'S MAIDEN NAME <u>Henrietta Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>218-01-9495</u> 17. INFORMANT <u>Catherine Scott</u> Address <u>Grasonville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>tetrichopneumonia virus</u> DUE TO (b) <u>chronic asthmatic bronchitis</u> DUE TO (c) <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>65</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dec 16</u> 20f. (City or town) (County) (State) <u>Dec 21</u> <u>MD</u> <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 16</u> to <u>Dec 21</u> 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>Dec 20</u> 19 <u>65</u> and that death occurred at <u>8</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodor Sattelmaier</u> 22b. DATE SIGNED <u>Dec. 21, 1965</u> 22c. PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u> 22d. ADDRESS <u>STEVENSVILLE MARYLAND</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12-26-65</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Robertson's Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Grasonville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washell</u> 25a. REC'D BY REGISTRAR <u>DEC 27 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Queen Anne b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Arms Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS Washington Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) M. Irene Livingood		4. DATE OF DEATH Dec 29 1965	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/1887
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 14 Days 2 IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ira W. Kline		14. MOTHER'S MAIDEN NAME Laura Keller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-48-8760	
17. INFORMANT Fred Livingood		Address Washington Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Repeated Small Cerebral Thrombi 332X DUE TO (b) Far Advanced Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia Bronchio - 3 week ago			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1965 to Dec 29, 1965 , that (I) (we) last saw the deceased alive on Dec 27 1965 , and that death occurred at CHSM , from the causes and on the date stated above.			
22a. SIGNATURE C. R. Layton		22b. DATE SIGNED 12-28-65	
22c. PHYSICIAN'S NAME (Type) C. R. Layton		22d. ADDRESS Centerville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 31, 1965	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.		23d. LOCATION (City, town or county) (State) Myerstown, Penna.	
24. FUNERAL DIRECTOR J. Wilkins Wells		ADDRESS Chestertown, Md.	
25a. REC'D BY REGISTRAR DEC 30 1965		25b. REGISTRAR'S SIGNATURE Charles J. ...	

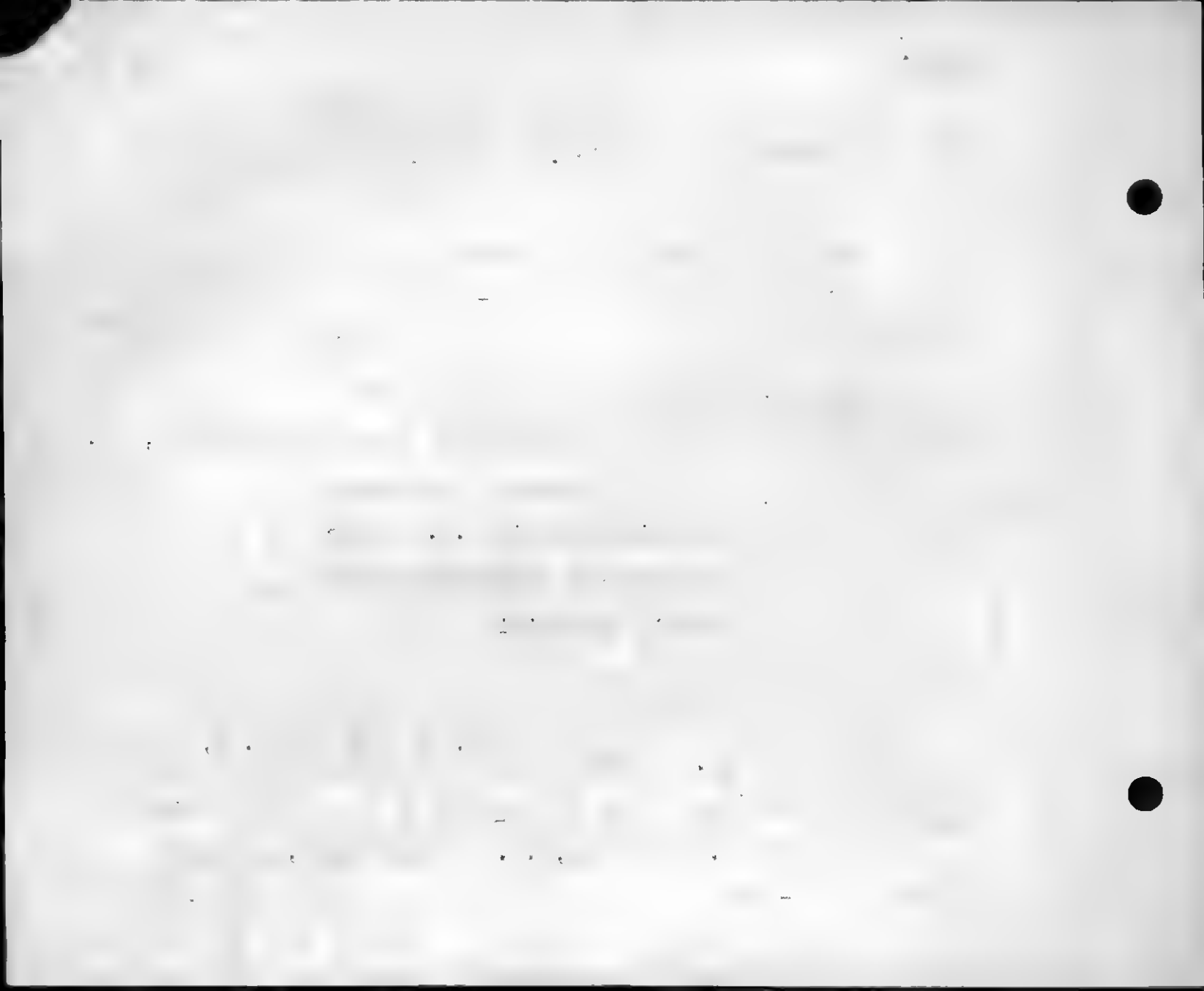
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16935 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Queen Anne b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville c. LENGTH OF STAY IN 1b 30 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Alonza Mc Comas			4. DATE OF DEATH 12 5 1965			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9-8-1895			9. AGE (In years last birthday) 70 yrs.			10. FINDER 1 YEAR Months Days Hours Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boiler Maker						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) West Virginia		
12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME Henry Mc Comas					
14. MOTHER'S MAIDEN NAME No Record						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO.						17. INFORMANT Address Vesta Mc Comas Sudlersville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO (b) Arteriosclerotic C.V.Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Bronchitis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1965 to Dec. 5, 1965 that (I) (we) last saw the deceased alive on Dec. 5, 1965 , and that death occurred at 930M , from the causes and on the date stated above.											
22a. SIGNATURE Charles H. Stonasifer, M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12/7/65											
22c. PHYSICIAN'S NAME (Type) Charles H. Stonasifer, M.D. 22d. ADDRESS Greensboro, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-8-65 23c. NAME OF CEMETERY OR CREMATORY Templeville 23d. LOCATION (City, town or county) (State) Templeville, Maryland											
24. FUNERAL DIRECTOR J.E. Boulaix Greensboro, Md. 25a. REC'D BY REGISTRAR DEC 13 1965 25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> c. LENGTH OF STAY IN 1b <u>ALL HIS LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> d. STREET ADDRESS <u>132 KIDWELL AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>MORRIS</u> Middle Last			4. DATE OF DEATH <u>DEC</u> Month <u>1</u> Day <u>1965</u> Year						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18, 1899</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE'S Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MORRIS</u>					14. MOTHER'S MAIDEN NAME <u>IDA ROE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>217-30-8403</u>		17. INFORMANT <u>Mrs. Jennie V. Morris, 132 Kidwell Ave, Centreville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 42+0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis Heart Disease Arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 year</u> <u>5 years</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1960</u> , to <u>Dec 1, 1965</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1965</u> , and that death occurred at <u>3p</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>John R. Smith, Jr.</u>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr. mo</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>Centreville, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>DEC. 3, 1965</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN MEMORIAL PARK, INC</u>		23d. LOCATION (City, town or county) (State) <u>Talbot County Maryland</u>		
24. FUNERAL DIRECTOR <u>James H. Butler, Butler Bros., Centreville, Md.</u>					25a. REC'D BY REGISTRAR <u>DEC 6 1965</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

16937

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

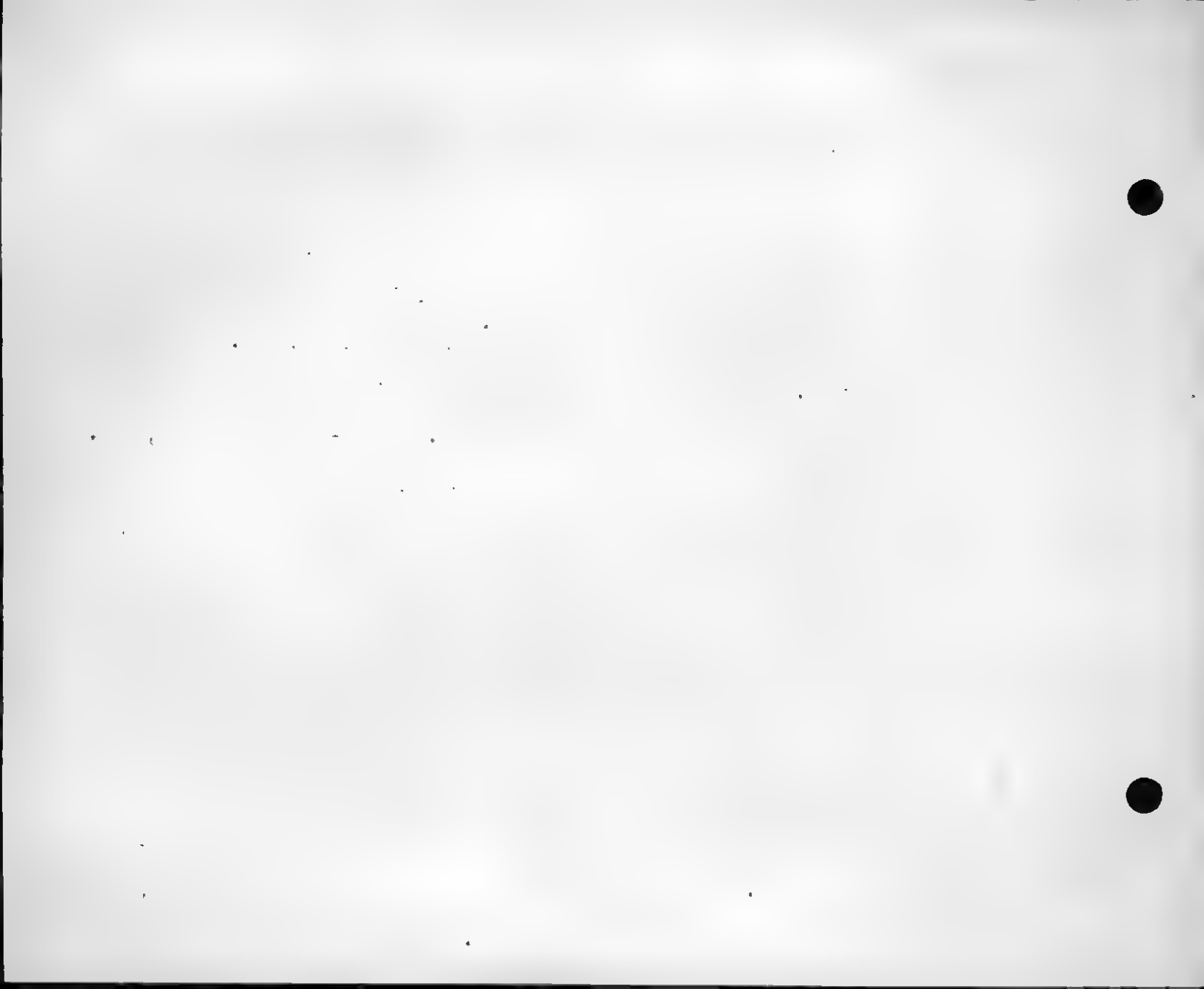
1. PLACE OF DEATH a. COUNTY QUEEN ANNE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ANNA ELIZABETH O'DONNELL				4. DATE OF DEATH Month Day Year DECEMBER 2 1965					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 26 - 1891		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY XX		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WESLEY HORNEY				14. MOTHER'S MAIDEN NAME SUSAN JANE BRYAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX				16. SOCIAL SECURITY NO. XX		17. INFORMANT Address MRS. ALVIN HOLDEN = GRASONVILLE MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardio Vascular disease DUE TO (c) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 10 min years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE C. Rodney Layton				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 12-3-65	
EXAMINER'S NAME (Type) C. RODNEY LAYTON				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Centreville GA MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 4		23c. NAME OF CEMETERY OR CREMATORY CHESTER FIELD		23d. LOCATION (City, town or county) (State) CENTREVILLE MD.			
24. FUNERAL DIRECTOR Edgardo L. Lane				ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR DEC 13 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Queen Anne b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ann Elizabeth Potts			First Ann Middle Elizabeth Last Potts		4. DATE OF DEATH December 9 1965		Month December Day 9 Year 65		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 16, 1903		9. AGE (In years last birthday) 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restauranteur				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Stevensville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph E. Lane					14. MOTHER'S MAIDEN NAME Estella Shawn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 215-16-3027		17. INFORMANT Henry P. Lane--Stevensville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes								INTERVAL BETWEEN ONSET AND DEATH 15 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 9 Sep, 1961 to 9 Dec, 1965 , that (I) (we) last saw the deceased alive on 8 NOV 1965 , and that death occurred at 3 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Stephen P. Carney					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10 Dec 65		
22c. PHYSICIAN'S NAME (Type) STEPHEN P. CARNEY					22d. ADDRESS EASTON MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 12		23c. NAME OF CEMETERY OR CREMATORY Stevensville		23d. LOCATION (City, town or county) (State) Stevensville, Maryland			
24. FUNERAL DIRECTOR Edgar L. Lane					ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR DEC 20 1965		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>										
1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sudlersville c. LENGTH OF STAY IN ID 2 yr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sudlersville d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frederick C. Weitz			4. DATE OF DEATH 12-20 19 65		5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-12-1891			9. AGE (In years last birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frederick Weitz			14. MOTHER'S MAIDEN NAME Theresa Goetz			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Lillian Weitz			Address Sudlersville, Md.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4221 Acute myocardial infarction Chronic myocardial infarction Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fatty Heart	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NO			20c. TIME OF INJURY Month, Day, Year 12 19 65 Hour a.m. 11 p.m. 16	
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) (County) (State) Sudlersville, Queen Anne, Md.			21. I certify that (I) (this hospital) attended the deceased from Dec 19, 1965, to Dec 20, 1965, that (I) (we) last saw the deceased alive on Dec 19, 1965, and that death occurred at 3 PM, from the causes and on the date stated above.	
22a. SIGNATURE C. H. METCALFE			22b. DATE SIGNED DEC 27 1965			22c. PHYSICIAN'S NAME (Type) C. H. METCALFE			22d. ADDRESS Sudlersville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-23-65			23c. NAME OF CEMETERY OR CREMATORY Greensboro			23d. LOCATION (City, town or county) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR John E. Boula's			ADDRESS Greensboro, Md.			25a. REC'D BY REGISTRAR DEC 27 1965			25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Queen Anne's County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D.#1 Chestertown, Md. c. LENGTH OF STAY IN b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D.#1 Chestertown, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Hallie		First Hallie		Middle Wilson		Last Wilson		4. DATE OF DEATH Month 12/ Day 12 Year 1965	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/1911		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (County & State, or foreign country) Queen Anne's County		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME William Wilson				14. MOTHER'S MAIDEN NAME Lydia Elloit					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-6684		17. INFORMANT Galen Wilson		Address R.F.D.#1 Chestertown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Systemic lupus erythematosis 456x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 - 4 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from 12/12 , 19 65 to 12/12 , 19 65 that (I) (we) last saw the deceased alive on 12/12 , 19 65 , and that death occurred at 1 A.M., from the causes and on the date stated above.									
22a. SIGNATURE Robert W. Farr						22b. DATE SIGNED 12-13-65			
22c. PHYSICIAN'S NAME (Type) Robert W. Farr M.D.						22d. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/1965		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.		23d. LOCATION (City, town or county) (State) Near Millington, Md.			
24. FUNERAL DIRECTOR Kenneth Waddy						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DEC 16 1965	
						25b. REGISTRAR'S SIGNATURE Charles Judge			

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